

FILE No. G 132 MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

04272

1. PLACE OF DEATH  
COUNTY

MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED  
STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
TOWNLENGTH OF STAY  
(In this place)CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWNHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSSTREET  
ADDRESS  
(If rural, give location)3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

## 5. SEX

## 6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH

## 9. AGE last birthday

If under 1 year If under 24 hrs.  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME

## 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If year, give year or dates of  
service)

## 16. SOCIAL SECURITY No.

## 17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Arterio-sclerotic Hypertensive

## Antecedent cause(s)

(b) Cardio-renal disease

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(c) Fracture neck left femur

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY at home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY exact date unknownINJURY OCCURRED  
While at Not While  
Work At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1951, to April 19, 1951, that I last saw the deceased  
alive on April 18, 1951, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG. 4/21/51 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

102 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

04273

Reg. Dist. No. 351

1. PLACE OF DEATH- COUNTY <b>Worcester</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Snow Hill, rural</b>		LENGTH OF STAY (If in place) <b>minutes</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Pocomoke</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Powellville Rd.</b>		<i>In transit to Hospital</i>		STREET ADDRESS (If rural, give location) <b>4096 Walnut St.</b>	
3. NAME OF DECEASED (Type or Print) <b>NORMA</b>		(First) <b>LOUISE</b>		(Last) <b>BELCHER</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Apr 13, 1951</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Oct 17 1928</b>		9. AGE last birthday <b>22</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Eward W. Redden</b>		14. MOTHER'S MAIDEN NAME <b>Thelma F. Figgs</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY No. <b>218-20-9700</b>		17. INFORMANT AND ADDRESS (Name) <b>Mrs Thelma Redden, Pocomoke, Md.</b>	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
825.5 Immediate cause <b>Thrombosis from Lung &amp; Neck broken</b>		(a)	
1700 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <b>Auto accident</b>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office, etc.) <b>Forest Lake, Pa</b>		(CITY OR TOWN) <b>3 1/2 miles from Snow Hill</b> (COUNTY) <b>Worcester</b> (STATE) <b>Md</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 13 1951 7:00 PM</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <b>Auto accident</b>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <b>Dr. J. B. Santorus</b>		ADDRESS <b>Pocomoke City, Md</b>	
DATE SIGNED <b>4/15/51</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>4/17/51</b>	
NAME OF CEMETERY OR CREMATORY <b>Beth Eden Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pocomoke RFD, Md.</b>	
DATE REC'D BY LOCAL REG. <b>4/17/51</b>		REGISTRAR'S SIGNATURE <b>Robert Smith</b>	
24. FUNERAL DIRECTOR <b>Henry H. Watson</b>		ADDRESS <b>Pocomoke, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 20 1951  
BUREAU V. S.

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 355

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>CLEAN CITY</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New York</u> COUNTY <u>CATTARAUGUS</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>LITTLE VALLEY</u> OR TOWN STREET ADDRESS (If rural, give location) <u>507 FAIR OAKS ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>DEAN</u> (First) <u>J</u> (Middle) <u>CASE</u> (Last)		4. DATE OF DEATH <u>APRIL 3</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 19, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Race Horses</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Stable</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cattaraugus County N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jean Case</u>		14. MOTHER'S MAIDEN NAME <u>Lola Brinsworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ms. D. J. Case</u>	
17. INFORMANT AND ADDRESS <u>507 Fair Oaks St. Little Valley N.Y.</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Disease, Instantaneous  
 Antecedent cause(s) (b) History of Coronary Thrombosis last year  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION Walking facing a strong northwest wind and rain.

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☐

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/3/51

Helen F Hayward

A. Burroughs Berlin Md.

051859

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 4, 9, on:  
 Form No. G 132 MAY 15 1951

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
TOWN <u>Berlin</u>		TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Flower St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Emmal Louise</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 28, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmal Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Taylor Franklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dated of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. Charles J. Denney Berlin Md</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Thrombosis

(b) Arteriosclerosis & Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 days

18 months

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

None

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23, 1950, to 4/25, 1951, that I last saw the deceased

alive on 4/25, 1950, and that death occurred at 6:45 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

T. J. O'Donnell M.D.

Berlin, Md.

4/26/51

#### 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/27/51

Helena F. Haywood

James A. Burkay Berlin Md

RECEIVED

MAY 9 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

04276

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shawell</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Shawell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>No #</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Curtis</u> (Middle) <u>Hudson</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>9</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>April 25, 1965</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owned his own farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>85</u> yrs.
13. FATHER'S NAME <u>James Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Buchanan</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
		17. INFORMANT AND ADDRESS <u>Jennie E. Hudson Shawell, Md</u>	
		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chr. Myocarditis</u>			
Antecedent cause(s) (b) <u>Chr. Bronchial Asthma</u>			<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Shawell Worcester</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1951, to 4-9, 1957, that I last saw the deceased alive on 4-7-, 1957, and that death occurred at 1:30 A. m., from the causes and on the date stated above.

SIGNATURE Chas. R. Law, M.D. (Degree or title) ADDRESS Berlin Md DATE SIGNED April 9-57

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/11/57</u>	NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>	LOCATION (City, town, or county) <u>Bishopville, Md.</u>
DATE REC'D BY LOCAL REG. <u>4/10/57</u>	REGISTRAR'S SIGNATURE <u>Helen F Hayward</u>	24. FUNERAL DIRECTOR <u>Edwin Whaley Selbyville</u>	ADDRESS <u>100105 del.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1951

BUREAU V. S.

04277

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 350

1. PLACE OF DEATH- COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Side St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke City</u> STREET ADDRESS (If rural, give location) <u>6th &amp; Pacific Pocomoke Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Harley</u> (First) <u>Jones</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>24</u> (Year) <u>51</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1882</u> <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garden work</u>		11. BIRTHPLACE (State or foreign country) <u>(?)</u>	
13. FATHER'S NAME <u>David Jones</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		17. INFORMANT AND ADDRESS <u>Cicero Johnson Pocomoke City, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Coronary disease</u> Antecedent cause(s) (b) <u>420.1 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c) <u>94a</u>		<u>Instant</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Too strenuous work.</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) CAUSE OF DEATH INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Dr. M. J. Jones (Degree or title) ADDRESS Pocomoke City, Md. DATE SIGNED 4/5/51

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 1, 1951</u>	<u>Unionville Methodist</u>	<u>Pocomoke, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR.	ADDRESS
<u>May 1, 1951</u>	<u>Anne E. White</u>	<u>Henry H Watson</u>	<u>Pocomoke, Md.</u>

MARGIN RESERVED FOR BINDING

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RECEIVED  
1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04278 350

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u> LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>New Church</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Redden Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARA</u> (Middle) <u>VIRGINIA</u> (Last) <u>KELLEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 8, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Sept 23 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>William Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wise Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sarah Kelly, Ocean City, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonia, Terminal</u>			<u>4 days</u>
Antecedent cause(s) (b) <u>Diabetes Mellitus</u>			<u>Unknown</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senescence</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 4, 1951, to April 8, 1951, that I last saw the deceased alive on April 7, 1951, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

SIGNATURE Charles W. Trader, M.D. ADDRESS Pocomoke City, Md. DATE SIGNED Apr. 10, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/11/51</u>	NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>	LOCATION (City, town, or county) (State) <u>Pocomoke, Rt 3, Md.</u>
DATE REC'D BY LOCAL REG. <u>April 11, 1951</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Henry H. Watson, Pocomoke, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 10 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6th St.</u>		STREET ADDRESS (If rural, give location) <u>6th St.</u>	
3. NAME OF DECEASED (Type or Print) <u>EMMA</u>	(First) (Middle) (Last) <u>LANE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 10, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 15 1877</u>
9. AGE last birthday <u>73</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Gordon Jester</u>	
14. MOTHER'S MAIDEN NAME <u>Irene Matthews</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Lloyd Lane, Pocomoke, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Stroke</u>		19. DATE OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Antecedent cause(s) <u>Probably due to Embolism</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cardiac disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. I hereby certify that I attended the deceased from <u>April 5, 1951</u> , to <u>April 10, 1951</u> , that I last saw the deceased alive on <u>April 5, 1951</u> , and that death occurred at <u>4:10 p.m.</u> , from the causes and on the date stated above.	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS <u>Henry H. Watson, Pocomoke, Md.</u>	

25. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4/15/51</u>		NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Baptist</u>		LOCATION (City, town, or county) <u>Pocomoke, Md.</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 15, 1951</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>		26. FUNERAL DIRECTOR ADDRESS <u>Henry H. Watson, Pocomoke, Md.</u>					

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 18 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04280 353

1. PLACE OF DEATH COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>	
TOWN <u>Bishopville</u>		TOWN <u>Bishopville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>No #</u>	
3. NAME OF DECEASED (Type or Print) <u>Nancie</u> (First) <u>B.</u> (Middle) <u>Laughery</u> (Last)		4. DATE OF DEATH <u>April 15</u> 19 <u>51</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb 27 1876</u>	
9. AGE last birthday <u>74</u> yrs.		10. If under 1 year Months Days If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>James Laughery Bishopville</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
Antecedent cause(s) (b) <u>Hypertension</u>		<u>10 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Dec 50</u> , 19 <u>50</u> , to <u>Apr 16 51</u> , that I last saw the deceased alive on <u>Apr 15</u> , 19 <u>51</u> , and that death occurred at <u>3:30</u> p.m., from the causes and on the date stated above.					
SIGNATURE <u>Robert Long</u>		ADDRESS <u>W. M. Young, M.D., Frankford, Del.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>April 18 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Bishopville</u>	
LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>		24. FUNERAL DIRECTOR <u>John Whaley</u>		ADDRESS <u>Bishopville, Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 9 on:

MAY 15 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>10 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u> OR TOWN STREET ADDRESS (If rural, give location) <u>Bishop, Md. R.F.D.</u>	
3. NAME OF DECEASED (Type or write) <u>Myor E. (First) Moores Lee (Middle) (Last)</u>		DATE OF DEATH <u>April 19, 1951</u>		DATE OF BIRTH <u>Sept 19, 1901</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Sept 19, 1901</u>	9. AGE last birthday <u>49</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Bell Air, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry F. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Alice Gentrylighter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or date of discharge) <u>World War I, 1917-1918</u>	
16. SOCIAL SECURITY NO. <u>1-100-100000</u>		17. INFORMANT AND ADDRESS <u>Mary Webb Lee, Bishop, Md. R.F.D.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Immediate cause (a) <u>Coronary occlusion &amp; myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
Antecedent cause(s) (b) <u>Angina pectoris</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		?	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 18, 1951</u> , to <u>April 19, 1951</u> , that I last saw the deceased alive on <u>April 18, 1951</u> , and that death occurred at <u>9 A</u> m., from the causes and on the date stated above.					
SIGNATURE <u>William N. Young M.D.</u>		ADDRESS <u>Selbyville, Del.</u>		DATE SIGNED <u>April 24, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4/23/51</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	
LOCATION (City, town, or county) <u>Washington</u>		24. FUNERAL DIRECTOR <u>M. R. Borgey</u>		ADDRESS <u>Selbyville, Del.</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 21, 1951</u>		REGISTRAR'S SIGNATURE <u>M. R. Borgey</u>		25. FUNERAL DIRECTOR <u>M. R. Borgey</u>	

673916

RECEIVED  
APR 24 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

04282

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Bygon Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Columbus</u>	(Middle) <u>William</u>	(Last) <u>Marshall</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 30, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Berlin md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Sulghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C.W. Marshall Berlin md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Myocarditis, degenerative, & Anemia

INTERVAL BETWEEN ONSET AND DEATH

1 yr.

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Heart Disease see & Gen. Atherosclerosis

5 yrs

(c) Arteritis Syphilitica, severe, & ankylosis

4 yrs

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Bilateral, dilated & indurated Angina pectoris

25 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1947, to 2<sup>nd</sup> Apr., 1951, that I last saw the deceased

alive on 2 Apr., 1951, and that death occurred at 2:5A m., from the causes and on the date stated above.

SIGNATURE Herman R. Robbins md. ADDRESS 5848 Berlin md. DATE SIGNED 4 Apr 51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>4/4/51</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/7/51</u>	<u>Helen F Hayward</u>	<u>Anna A. Burdick</u>	<u>Berlin md</u>	

325906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04283

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
TOWN <u>Newark</u>		TOWN <u>Newark</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Mathew</u> (Middle) <u>M.</u> (Last) <u>Mason</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 11, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Horntown, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peter Mason</u>		14. MOTHER'S MAIDEN NAME <u>Annie Corbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Virginia Matthews Newark, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Apoplexy</u>				<u>2 wks</u>	
442X Antecedent cause(s) (b) <u>Peter's arteriosclerotic Renal disease</u>				<u>unknown</u>	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/20, 1951, to 4/10, 1951, that I last saw the deceased alive on 4/9, 1951, and that death occurred at 8:15 A m., from the causes and on the date stated above.

SIGNATURE <u>Paul Green</u>		(Degree or title) <u>Md</u>		ADDRESS <u>Snow Hill Md</u>		DATE SIGNED <u>4/13/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>April 13/51</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity</u>		LOCATION (City, town, or county) <u>Newark</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>4/13/51</u>		REGISTRAR'S SIGNATURE <u>P. E. Smith</u>		24. FUNERAL DIRECTOR <u>Wm. E. Smith</u>		ADDRESS <u>Snow Hill Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

SEP 16 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

04284

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shaler</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>		STREET ADDRESS (If rural, give location) <u>No 11 Williams St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Samuel A. Moore</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 20, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If year, give war or dates of service)	
11. BIRTHPLACE (State or foreign country) <u>Delaware Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Harrison</u>	
15. INFORMANT AND ADDRESS <u>Mrs. Melissa Moore Berlin Md</u>		16. SOCIAL SECURITY No. <u>✓</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Chronic myocarditis</u>		<u>4 yrs</u>	
Antecedent cause(s) (b) <u>Hypertension</u>		<u>8 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>47</u> , to <u>day of death</u> , that I last saw the deceased alive on <u>4-24-51</u> , 19 <u>51</u> , and that death occurred at <u>12:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Frank K. Lewis M.D.</u>		ADDRESS <u>Williams St. Maryland</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4/27/51</u> NAME OF CEMETERY OR CREMATORY <u>St. John's</u> LOCATION (City, town, or county) <u>Berlin Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>4/27/51</u>		REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u> 24. GENERAL DIRECTOR <u>Peter Whaley</u> ADDRESS <u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

335906

RECEIVED  
MAY 1 1961  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

04285

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 357

1. PLACE OF DEATH COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Shaw Hill, rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pocomoke</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Powellville Rd.</b>		STREET ADDRESS (If rural, give location) <b>4th &amp; Cedar Sts.</b>	
3. NAME OF DECEASED (First) <b>EDITH</b> (Middle) <b>N.</b> (Last) <b>NASH</b>		4. DATE OF DEATH (Month) <b>Apr.</b> (Day) <b>13,</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept 2 1924</b>
9. AGE last birthday <b>26</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife &amp; waitress</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William E. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Helen W. Pilchard</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>218-20-7385</b>	
17. INFORMANT AND ADDRESS <b>Mr. William E. Myers, Pocomoke, Md.</b>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <b>8935 Fractured Skull &amp; Hemorrhages</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
Antecedent cause(s) <b>170c Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</b>		<b>Auto - accident</b>	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory street, office bldg, etc.) INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) (Minute) <b>April 13 1951 8 P.M.</b>		CITY OR TOWN <b>Shaw Hill - Worcester Md</b>	
HOW DID INJURY OCCUR? <b>Turned over when driving</b>		DATE SIGNED <b>4/15/51</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		ADDRESS <b>Pocomoke City, Md</b>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>4/17/51</b>	
NAME OF CEMETERY OR CREMATORY <b>Hall's Hill Baptist</b>		LOCATION (City, town, or county) (State) <b>Pocomoke, Md.</b>	
DATE REC'D BY LOCAL REG. <b>4/17/51</b>		REGISTRAR'S SIGNATURE <b>Reley Smith</b>	
24. FUNERAL DIRECTOR <b>Henry H. Watson, Pocomoke, Md.</b>		ADDRESS <b>Pocomoke, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AISA

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RECEIVED  
JAN 20 1951  
BUREAU V. S.

04286

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
TOWN <u>Berlin</u>		TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Flower Street</u>		STREET ADDRESS (If rural, give location) <u>Flower St</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Pitts</u> (Last) <u>Pitts</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>aa</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>about 1883</u>
9. AGE last birthday <u>about 68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Berlin Worcester Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin Worcester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mamie Bowen, Berlin, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Chronic Degenerative Myocarditis & Coronary Sclerosis

## Antecedent cause(s)

(b) Atherosclerosis, Sclerotic

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Atherosclerosis, Sclerotic

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Prostate Gland, Hypertrophy & Hyaline Sclerosis + Cystitis

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Apr, 1951, that I last saw the deceased alive on 1 Apr, 1951, and that death occurred at 7:45 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

4/4/51Helen F HaywardJames B. Dashiell, Salisbury, Maryland

MARGIN RESERVED FOR BINDING

VS. A151

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APR 9 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

04287

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree</u>	
TOWN <u>Girdletree</u>		TOWN <u>Girdletree</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Emma</u>	(Middle) <u>V.</u>	(Last) <u>Rew</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 17-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cham Home</u>	9. AGE last birthday <u>73</u> 11/27 yrs.
13. FATHER'S NAME <u>Joseph Sterling</u>		11. BIRTHPLACE (State or foreign country) <u>Hallwood Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Russell Tilchard, Girdletree, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Pulmonary Edema</u>			<u>1 hr</u>
Antecedent cause(s) (b) <u>Chronic Cardiac Failure</u>			<u>2 wks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Labar Pneumonia</u>			<u>2 wks</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from March 25, 1951, to April 10, 1951, that I last saw the deceased alive on April 10, 1951, and that death occurred at 11:58 P.m., from the causes and on the date stated above.

SIGNATURE <u>Dr. La Mar</u>		ADDRESS <u>Girdletree, Md.</u>		DATE SIGNED <u>4-12-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baptist</u>	LOCATION (City, town, or county) <u>Girdletree, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>4/13/51</u>	REGISTRAR'S SIGNATURE <u>LeRoy Smith</u>	24. FUNERAL DIRECTOR <u>Wm. C. Morris</u>		ADDRESS <u>Girdletree, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

04288

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Pocomoke</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sanford</u> VA	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Redding Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Sanford</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>Sitronthony</u> (Last) <u>Stant</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>2</u> (Year) <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 22 1885</u>
9. AGE last birthday <u>71</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>	11. BIRTHPLACE (State or foreign country) <u>Sanford Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	13. FATHER'S NAME <u>William Sitronthony Stant</u>	14. MOTHER'S MAIDEN NAME <u>Emile Stant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>Martin Brewer, Saline, Va.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cancer of the Bladder</u>		
Antecedent cause(s) (b) <u>Heart Disease, Degenerative</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>52</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 25, 1951, to April 2, 1951, that I last saw the deceased alive on April 1, 1951, and that death occurred at 5:35a m., from the causes and on the date stated above.

SIGNATURE <u>Charles W. Trader M.D.</u>	DATE SIGNED <u>4-3-51</u>
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE <u>4/4/51</u>
NAME OF CEMETERY OR CREMATORY <u>Lewis Cent Sanford</u>	LOCATION (City, town, or county) <u>Sanford Va</u>
DATE REC'D BY LOCAL REG. <u>April 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>
24. FUNERAL DIRECTOR <u>J. B. Johnson</u>	ADDRESS <u>Rockledge, Va</u>

MARGIN RESERVED FOR BINDING

VS. A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH - COUNTY <u>Winchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Winchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Trope RD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wilbur</u> (Middle) <u>Caswell</u> (Last) <u>Stout</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>19</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 5, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurseryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bethuel Stout</u>		14. MOTHER'S MAIDEN NAME <u>Marion Best</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year and dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. W.C. Stout Berlin Ind.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Chr. Myocarditis

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chr. Nephritis

(c)

#### INTERVAL BETWEEN ONSET AND DEATH

10 days

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 10, 1951, to Apr. 19, 1951, that I last saw the deceased

alive on 4-19-, 1951, and that death occurred at 1230 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/23/51</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>Ind</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/21-51</u>	<u>Helen F Hayward</u>	<u>Anna D. Kurbage</u>	<u>Berlin Ind</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED  
APR 24 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

04290

Reg. Dist. No. 351

1. PLACE OF DEATH: COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark, W.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark Md Rural.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Clifton Edward Lindley</u>		4. DATE OF DEATH <u>April 29 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4/9/07</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	9. AGE last birthday Months <u>20</u> Days <u>19</u> Yrs. <u>42</u>
11. BIRTHPLACE (State or foreign country) <u>Whaleyville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter H. Lindley</u>		14. MOTHER'S MAIDEN NAME <u>Edna C. Foreman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Peter H. Lindley, Newark, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Broncho pneumonia</u>			<u>Unknown</u>
(b) <u>Lack of Attention</u>			<u>"</u>
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frederick S. Swannick M.D. SMC</u>		DATE SIGNED <u>4/29/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Peter's</u>	
DATE REC'D BY LOCAL REG.		FUNERAL DIRECTOR ADDRESS	
<u>4/30/51</u>		<u>Clayton D. Harris, Snow Hill, Md</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 2 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 354

04291

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stocketon Rural #1</u> LENGTH OF STAY (In this place) <u>23 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stocketon Rural #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Nellie</u> (First) <u>M.</u> (Middle) <u>Traders</u> (Last)		4. DATE OF DEATH <u>April 4</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 29 - 1903</u> 48 <u>2</u> <u>5</u> yrs. (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>48</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Meigsville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alexander W. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Agers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Bessie Paulson Hallum, Fla.</u>		18. MEDICAL CERTIFICATION	

### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

(b)

Diabetes Mellitus

unknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 4, 1946, to April 4, 1951, that I last saw the deceased alive on April 2, 1951, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 8/51</u>	<u>Traders</u>	<u>Stocketon</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr 5 - 1951</u>	<u>Mary M. Taylor</u>	<u>W. C. Snow</u>	<u>W. C. Snow, N. H. Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pocomoke</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stockton</u> LENGTH OF STAY (in this place) <u>9 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>R</u> (Last) <u>Waters</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>2</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 8, 1859</u> 9. AGE last birthday <u>92</u> yts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Pocomoke Maryland</u>
13. FATHER'S NAME <u>Littleton Waters</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
		17. INFORMANT <u>Bertha Purnell daughter</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Uremia</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>1 wk</u>
Antecedent cause(s) (b) <u>Arteriosclerotic hypertensive cardio-vascular renal disease</u>			<u>unknown</u>
(c) <u>none</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>none</u>	<u>none</u>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 1, 1951, to April 2, 1951, that I last saw the deceased alive on April 1, 1951, and that death occurred at 6:45 P m., from the causes and on the date stated above.

SIGNATURE Hane Chen (Degree or title) md ADDRESS Snow Hill Md DATE SIGNED 4/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 8, 1951</u>	<u>Unionville Cemetery</u>	<u>Pocomoke-Rural</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Apr. 9, 1951</u>	<u>Mary M. Taylor</u>	<u>Bradshaw Funeral Parlor, Cinfield, Md.</u>		

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RECEIVED

APR 12 1951

BUREAU V. S.